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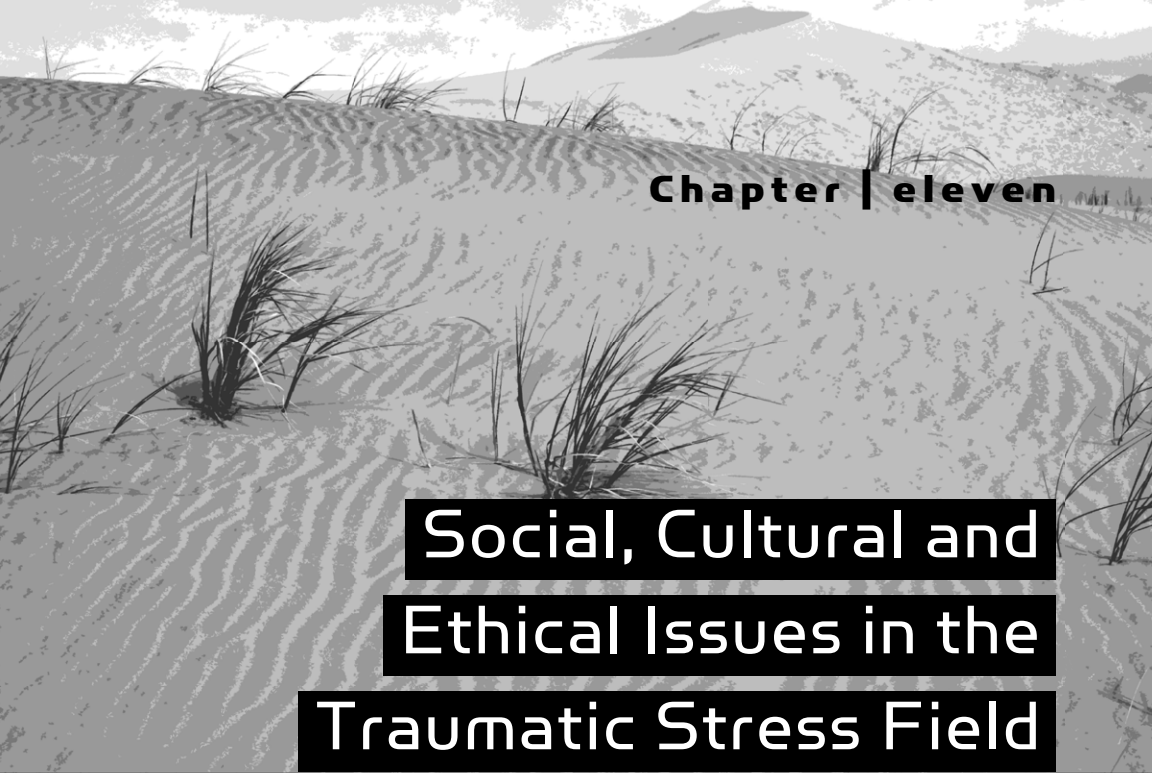

Chapter | eleven

Social, Cultural and Ethical Issues in the Traumatic Stress Field

This chapter describes how the impact of psychological trauma differs depending upon the social and cultural context and the social and cultural resources available to individuals, families and communities. Disadvantaged persons and communities such as those experiencing poverty, stigma and discrimination, disabilities, homelessness, political repression, communal/societal violence (including military and gang warfare), forced immigration (refugees), interrogation and torture, terrorism, genocide and catastrophic disasters are particularly vulnerable both to being exposed to traumatic stressors and to developing PTSD and associated psychiatric disorders and psychosocial problems (Herrera Rivera, De Jesus, Baxter Andreoli, Ines Quintana, & Pacheco De Toledo, 2008; Seedat, Nyamai, Njenga, Vythilingum, & Stein, 2004). This vulnerability largely is explained by the presence of chronic stressors (such as stigma, discrimination and poverty) and exposure to chronic or particularly horrific traumatic stressors (including the often lengthy aftermath of catastrophic disasters or societal conflicts), rather than being due to ethnic or cultural differences.

The extent and impact of exposure to traumatic stressors experienced by each of these vulnerable populations will be discussed, as well as the efforts of international non-governmental organizations (NGOs) to provide them with resources in order to reduce their exposure to traumatic stressors or to mitigate the adverse effects of traumatic exposure and PTSD.

Posttraumatic Stress Disorder: Scientific and Professional Dimensions
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KEY POINTS

1. Culture, ethnicity, gender, sexual orientation and disability are potential sources of resilience, but they also may lead to chronic stressors such as social stigma, discrimination and oppression which increase psychological trauma and PTSD.
2. Cumulative adversities are faced by many persons, communities, ethnocultural minority groups and societies that may lead to – as well as worsen the impact of – PTSD:
   - Persons of ethnoracial minority backgrounds
   - Persons discriminated against due to gender or sexual orientation
   - Persons with developmental or physical disabilities
   - Economically impoverished persons and groups, including the homeless
   - Victims of political repression, genocide, 'ethnic cleansing' or torture
   - Persons chronically or permanently displaced from their homes and communities due to catastrophic armed conflicts or disasters
3. Members of ethnoracial minority groups have been found to be more likely in some cases to develop PTSD than other persons, but in other cases they are *less* likely to develop PTSD (e.g. persons of Asian or African descent).
4. Members of ethnoracial minority groups often encounter disparities in access to social, educational, economic and healthcare resources; it is these disparities that are the most likely source of the increased vulnerability of these persons to psychological trauma and PTSD.
5. PTSD therapists must avoid stereotypic assumptions in order to ensure that assessment and treatment are genuinely collaborative and sensitive to each client's ethnocultural and other expectations, goals and preferences. A culturally competent approach to treating PTSD begins with a collaborative discussion in which the therapist adopts the stance of a respectful visitor to the client's outer and inner world – clarifying the client's expectations and preferences and the meaning of sensitive interpersonal communication modalities (such as spatial proximity, gaze, choice of names, private versus public topics, synchronizing of talk and listening, use of colloquialisms, providing advice or education).
6. A systematic assessment of trauma history and PTSD thus should include not only a listing of events and symptomatic or resilient responses in the aftermath, but how the person interpreted these events and reactions based on their cultural framework, beliefs and values.
7. In contrast to the general pattern of stigma-related violence being directed toward girls and women, gay and bisexual boys and men were more likely to report violent victimization or threats than lesbian or bisexual women or girls. The findings from a survey of gay, lesbian and bisexual (GLB) adolescents suggest that stigma and victimization begin early in life, with physical and sexual attacks occurring as early as ages 8–9 years old. One in 11 GLB adolescents have PTSD, as much as 20 times more than other children and adolescents.

8. Poverty puts people at risk for traumatic violence and not having a stable residence (homelessness) compounds this risk and further increases the likelihood of developing PTSD.
9. Political repression, genocide and mass armed conflicts involve psychological (and often physical as well) assaults by the people and institutions in power on people, families, communities and organizations who are deprived of access to political power and socioeconomic resources – and therefore also on their fundamental freedoms and values. Without access to self-determination and the resources necessary to sustain independence, people are vulnerable not just to traumatic exploitation and violence but also to the traumatic loss of their intimate relationships, their families, their way of life and their values.
10. Refugees and 'internally displaced' or 'stateless' persons who have been displaced from or lost their families, homes and communities due to armed conflicts or mass disasters (such as tsunamis, hurricanes or earthquakes) are at least ten times (and as much as thirty times) more likely than other children or adults to develop PTSD, with as many as one in three refugees or disaster survivors developing acute stress disorder or PTSD.

THE ROLE OF ETHNICITY, CULTURE, AND SOCIAL RESOURCES IN PTSD

Every individual, family and community has a heritage that includes a distinctive blend of racial, ethnic, cultural and national characteristics. Within this heritage there often also is a legacy of personal or familial exposure to psychological trauma. Psychological trauma and PTSD occur across the full spectrum of racial, ethnic and cultural groups in the USA (Pole et al., 2008). Psychological trauma and PTSD are epidemic internationally as well, particularly for ethnoracial minority groups (which include a much broader range of ethnicities and cultures and manifestations of PTSD than typically recognized in studies of PTSD in the USA; De Jong et al., 2005; De Jong et al., 2003). The scientific and clinical study of PTSD and its treatment among ethnoracial majority and minority groups is of great importance, especially given the disparities, adversities and traumas to which ethnoracial minorities have been subjected historically (Miranda, McGuire, Williams, & Wang, 2008) – and to which they are still exposed in health and health care, education and income and adult criminal and juvenile justice (Ford, 2008c, 2008e).

Although Latinos (and possibly African Americans) persons are at greater risk than European Americans for PTSD (Pole et al., 2008), it is possible that the elevated prevalence may be due to differences in the extent or types of exposure to psychological trauma (including prior traumas that often are not assessed in PTSD clinical or epidemiological studies; Eisenman et al., 2003) or to differences in exposure to other risk or protective factors such as poverty or education (Turner and Lloyd, 2003, 2004). In addition, there is sufficient diversity (in norms, beliefs, values, roles, practices, language and history) *within* categorical ethnocultural groups such as African Americans or Latinos to call into question any sweeping generalizations about their exposure and vulnerability or resilience to psychological trauma (Pole et al., 2008).

Race, ethnicity and culture tend to be described with shorthand labels that appear to distinguish homogeneous sub-groups, but that actually obscure the true heterogeneity within as well as between different ethnocultural groups (Marsella et al., 1996). One partial antidote for this problem is for clinicians and researchers to ask study participants or clinical patients to self-identify their own racial, ethnic and cultural background (Brown et al., 2006). It also is important carefully to assess factors that are associated with differential exposure to adverse experiences (such as racial-ethnic discrimination) or differential access to protective resources (such as income, healthcare, education), rather than assuming that each member of an ethnocultural group is identical on these crucial dimensions. However, when systematic disparities in exposure to stressors or deprivation of resources are identified for specific ethnocultural groups, such as persons from indigenous cultures – the original inhabitants of a geographic area who have been displaced or marginalized by colonizing national/cultural groups – are found to have a generally increased risk of discrimination, poverty or poor (Harris et al., 2006; Liberato et al., 2006), it is crucial not to conclude mistakenly that those persons' ethnic or cultural backgrounds make them less resilient than others when they are confronted with traumatic stressors. Commonly, the very opposite is true: persons and groups who are subjected to chronic stressors or deprivations tend to be *more* resilient than others, but they also are more exposed to and less protected from traumatic stressors (Pole et al., 2008).

Racism is a particular chronic stressor that is faced by many members of ethnoracial minority groups. Racism may increase the risk of exposure to psychological trauma, exacerbate the impact of psychological traumas and increase the risk of PTSD or constitute a form of psychological trauma in and of itself (Ford, 2008c). No studies have been reported that directly examine racism as a risk factor for exposure to psychological trauma. Studies based in the USA (Pole et al., 2008) and internationally (Macdonald et al., 1997) suggest that racial discrimination may have played a role in placing military personnel from ethnoracial minority groups at risk for more extensive and severe combat trauma exposure. Studies of survivors of the holocaust and other types of ethnic annihilation provide particularly graphic and tragic evidence of the infliction of psychological trauma *en masse* in the name of racism (Yule, 2000). Studies are needed that systematically compare persons and groups who are exposed to different types and degrees of racism in order to test whether (and under what conditions) racism is a form of, or leads to exposure to other types of, traumatic stressors (Ford, 2008c).

One study found that self-reported experiences of racial discrimination increased the risk of PTSD among Latino and African American police officers (Pole et al., 2005). When racism leads to the targeting of ethnoracial minority groups for violence, dispossession or dislocation, the risk of PTSD increases in proportion, type and degree of psychological trauma involved in these adverse experiences (Pole et al., 2008). Another study, with Asian American military veterans from the Vietnam War era showed that exposure to multiple race-related stressors that met PTSD criteria for psychological trauma was associated with more severe PTSD than when only one or no such race-related traumas were reported (Loo et al., 2005). This study more precisely operationalized racism than any prior study, utilizing two psychometrically validated measures of race-related

stressors and PTSD. However, as in the Pole et al. (2005) study, the stressors/traumas and PTSD symptoms were assessed by self-report contemporaneously, so the actual extent of racism experienced by the participants cannot be definitely determined. The Loo et al. (2005) study also did not control for traumatic stressor exposure other than that which was related to racism. In order to extend the valuable work these studies have begun, it will be important to utilize measures based on operationally specific criteria for categorizing and quantifying exposure to discrimination (e.g. Wiking et al., 2004) as a distinct class of adversities or stressors that can be assessed separately from as well as concurrently with exposure to psychological trauma.

Research also is needed to determine to what extent the adverse outcomes of racial disparities are the direct result of racism as a stressor (e.g. racially-motivated stigmatization, subjugation and deprivation), as opposed to the indirect effects of racism. Racism indirectly reduces access to protective factors (socioeconomic resources) that protect against the adverse effects of stressors (such as poverty, pollution) and traumatic stressors (such as accidents, crime or violence). It is important to determine whether PTSD is the product of either the direct or indirect effects of racism or both, particularly given its demonstrated association with other psychiatric disorders (such as depression) and with increased risk of physical illness (such as cardiovascular disease) in ethnoracial minorities (e.g. among American Indians; Sawchuk et al., 2005).

Education is a particularly relevant example of a socioeconomic resource to which ethnoracial minorities often have restricted access and that is a protective factor mitigating against the risk of PTSD (Dirkzwager et al., 2005) and overall health problems (Wiking et al., 2004). Racial disparities in access to education are due both to direct influences (such as lower funding for inner city schools that disproportionately serve ethnoracial minority students) and indirect associations with other racial disparities (such as disproportionate juvenile and criminal justice confinement of ethnoracial minority persons). Racial disparities in education are both the product of and a contributor to reduced access by ethnoracial minorities to other socioeconomic and health resources (such as income, health insurance; Harris et al., 2006). When investigating risk and protective factors for PTSD, it is essential, therefore, to consider race and ethnicity in the context not only of ethnocultural identity and group membership but also of racism and other sources of racial disparities in access to socioeconomic resources.

Although all ethnoracial minority groups tend to be disproportionately disadvantaged, particularly severe disparities in access to vital resources often are complicated by exposure to pervasive violence and by the loss of ties to family, home and community. When family and community relationships are severed – as occurs with massive political upheaval, war, genocide, slavery or catastrophic disasters – racial and ethnocultural groups may find themselves scattered and subject to exploitation. For example, there continue to be massively displaced populations in Central and South America, the Balkans, central Asia and Africa. When primary social ties are cut or diminished as a result of disaster, violence or political repression, the challenge expands beyond survival of traumatic life-threatening danger to preserving a viable life, community and culture in the face of life-altering losses (Garbarino and Kostelny, 1996; Rabalais et al., 2002). Ethnoracial

groups that have been able to preserve or regenerate core elements of their original cultural norms, practices and relationships within intact or reconstituted families may actually be particularly resilient to traumatic stressors and protected against the development of PTSD. For example, persons of Asian or African descent have been found to be less likely than other ethnocultural groups to develop PTSD, although whether this is true primarily or only for members of those groups who have sustained family integrity and cultural ties is a question that has not been scientifically studied and should be a focus for research (Pole et al., 2008).

A recurring theme is that the psychological trauma inflicted in service of racial discrimination may lead not only to PTSD but also to a range of insidious psychosocial problems that result from adverse effects upon the psychobiological development of the affected persons. When families and entire communities are destroyed or displaced, the impact on the psychobiological development of children and young adults may lead to complex forms of PTSD that involve not only persistent fear and anxiety but also core problems with relatedness and self-regulation of emotion, consciousness and bodily health that are described as 'complex PTSD' (Herman, 1992a) or 'disorders of extreme stress' (De Jong et al., 2005).

A critical question not yet answered by studies of PTSD and racial discrimination (Pole et al., 2005) and race-related stress (Loo et al., 2005), as well as by the robust literature that shows evidence of inter-generational transmission of risk for PTSD (Kellermann, 2001), is whether racism constitutes a 'hidden' (Crenshaw and Hardy, 2005) or 'invisible' (Franklin et al., 2006) form of traumatization that may be transmitted across generations. Recent research findings demonstrating highly adverse effects of emotional abuse in childhood (Teicher et al., 2006) are consistent with a view that chronic denigration, shaming, demoralization and coercion may constitute a risk factor for severe PTSD and associated psychobiological problems. Research is needed better to describe how emotional violence or abuse related to racism may (along with physical violence) constitute a form of traumatic stress and how this may adversely affect not only current but also future generations.

Providing culturally competent treatment to address the adverse impact of psychological trauma and PTSD requires principles and practices informed by this diversity of factors, rather than a 'black and white' view of race, ethnicity or culture that over-simplifies the individual's and group's heritage, nature and needs. Treatment preferences, such as who is the therapist as well as which therapy model is used, differ substantially not only across but also within ethnoracial groups (Pole et al., 2008). As a result, it is not possible as yet – and may never be possible – to prescribe precisely how best to select or train therapists and design or adapt therapies to fit different ethnocultural groups. A culturally competent (Brown, 2009) approach to treating PTSD (Ford, 2008c) begins with a collaborative discussion in which the therapist adopts the stance of a respectful visitor to the client's outer and inner world. This involves clarifying the client's expectations and preferences and the meaning of sensitive interpersonal communication modalities (such as spatial proximity, gaze, choice of names, private versus public topics, synchronizing of talk and listening, use of colloquialisms, providing advice

or education). PTSD therapists attempt to avoid stereotypic assumptions about race or culture, in order to ensure that assessment and treatment are genuinely collaborative and sensitive to each client's unique ethnocultural and other expectations, goals and preferences (Parson, 1997; Stuart, 2004).

Cultural competence means many things to many people and, unfortunately, often is mistakenly equated with being of the same racial, ethnic, cultural or national background as the persons involved in a study or receiving services or knowing in advance exactly what each person believes and expects, how they communicate with and are most receptive to learning from others and what their experience has been in relation to sensitive matters such as psychological trauma or PTSD (Ford, 2008c). This is likely to be a serious mistake. Sharing some general racial, ethnic, cultural or national features (or an apparently identical language or religion) is not synonymous with shared identity, knowledge or history. Even persons from what seem to be virtually identical backgrounds (such as monozygotic twins raised in the same family) are uniquely individual in many ways. Therefore, cultural competence should not be defined based upon being (supposedly) "just like" another person (in race, ethnicity, culture, language, or other type of background), but instead based upon a respectful interest in learning from each person and community what they have experienced and how they understand and are affected by psychological trauma and PTSD.

Culturally competent assessment of psychological trauma and PTSD with clients of ethnocultural minority groups requires several considerations (Hall, 2001; Marsella et al., 1996). In particular, it is essential not confront individuals with questions that are inadvertently disrespectful of their values or practices (e.g. including peyote as an example of an illicit drugs in a Native American tribe that uses it for religious rituals) or irrelevant (e.g. distinguishing blood family from close friends in a group that considers all community members as family). It also is important to assess factors that are helpful in determining the potential need for traditional forms of healing as well as standard medical or psychological treatments. For example, a systematic assessment of trauma history and PTSD thus should include not only a recitation of events in a person's life and symptomatic or resilient responses in the aftermath, but how the person interpreted these events and reactions based on their cultural framework, beliefs and values (Manson, 1996).

Interventions for prevention or treatment of PTSD typically have been developed within the context of the Western medical model (Parson, 1997). However, Hinton et al. (2005), Andres-Hyman et al. (2006), and Hwang (2006) offer examples of culturally-sensitive treatments. Evidence-based PTSD treatment models may work well with culturally-specific healing practices because they share the common the goal of fostering not just symptom reduction but a bolstering of resilience and mastery (see Chapters 7 and 8). Developing culturally specific and sensitive prevention or treatment interventions for PTSD, however, requires careful ethnographic study – that is, observing and learning about the values, norms, beliefs and practices endorsed and enforced by different cultural sub-groups. Ultimately the goal is that the PTSD clinician will truly work with – rather than imposing external assumptions and standards upon – the members of the wide range of ethnic and cultural communities (Ford, 2008c).

DISCRIMINATION DUE TO GENDER OR SEXUAL ORIENTATION AND PTSD

In most cultures, girls and women are subject to discrimination in the form of limitations on their access to crucial socioeconomic resources. Women earn 30–40% lower wages or salaries than men in most job classes in the USA (http://www.pay-equity.org/info.html) and Europe (http://www.eurofound.europa.eu/ewco/2007/01/ES0701049I.htm). Although girls and women are approaching parity with boys and men in access to education in most areas of the world (and exceed the enrollment of boys or men in secondary and college/university education), in sub-Saharan Africa and Asia, women and girls are as much as 33% less likely to be able to enroll in education and to have achieved literacy as adults (http://www.uis.unesco.org/template/pdf/EducGeneral/UISFactsheet_2008_No%201_EN.pdf).

Girls and women also may be systematically subjected to extreme forms of psychological and physical trauma as a result of their gender being equated with second-class citizenship and social norms that permit or even encourage exploitation. Sexual exploitation of women and girls is an international epidemic, including abuse and molestation, harassment, rape and punishment of rape victims, forced marriage, genital mutilation and sex trafficking or slavery (see Box 11.1). Physical abuse or assault of women and girls is tolerated and, in some cases, actually prescribed as a form of social control, in both mainstream cultures and sub-cultures that span the globe and include most religions and developed as well as developing or pre-industrial societies.

Similar potentially traumatic forms of violence are directed at many gay, lesbian, bisexual and transgender (GLBT) persons as a result of both formal and informal forms of social stigma and discrimination. Epidemiological studies have been conducted with samples of GLBT youths (D'Augelli et al., 2006) and adults (Herek, 2009) in the USA, suggesting that they are often subjected to potentially traumatic violence as a result of their non-traditional sexual orientation and behavior. Instances of violence *specifically related to sexual orientation* include:

- 5–10% of gay men and 10% of lesbians who were physically assaulted in the past year
- 20–32% of GLB adults who were subjected to actual or threatened violence toward their person or a property crime at some point in their lives
- 9–11% of GLB adolescents reported past incidents of physical or sexual violence.

In contrast to the general pattern of stigma-related violence being directed toward girls and women, gay and bisexual boys (D'Augelli et al., 2006) and men (Herek, 2009) were more likely to report violent victimization or threats than lesbian or bisexual women or girls. The findings from the survey of GLB adolescents suggest that stigma and victimization begins early in life, with physical and sexual attacks occurring as early as ages 8–9 years old. One in 11 GLB adolescents met criteria for PTSD, three to 20 times the prevalence of children (Copeland et al., 2007) and adolescents (Kilpatrick et al., 2000) in national samples in the USA.

BOX 11.1 'Making the Harm Visible': Sexual Exploitation of Women and Girls

Women from every world region report that the sexual exploitation of women and girls is increasing. All over the world, brothels and prostitution rings exist underground on a small scale and, on an increasingly larger scale, entire sections of cities are informally zoned into brothels, bars and clubs that house and often enslave women for the purposes of prostitution. The magnitude and violence of these practices of sexual exploitation constitutes an international human rights crisis of contemporary slavery. In *Prostitution: A Form of Modern Slavery*, Dorchen Leidholdt, the Co-executive Director of the Coalition Against Trafficking in Women, examines the definitions of slavery and shows how prostitution and related forms of sexual exploitation fit into defined forms of slavery.

In some parts of the world, such as the Philippines, prostitution is illegal, but well entrenched from providing 'recreational services' to military personnel. In *Blazing Trails, Confronting Challenges: The Sexual Exploitation of Women and Girls in the Philippines*, Aida F. Santos describes the harmful conditions for women and girls in prostitution in the Philippines, with problems related to health, violence, the legal system and services. In other regions, such as northern Norway, organized prostitution is a more recent problem, stemming from the economic crisis in Russia. In *Russian Women in Norway*, Asta Beate Håland describes how an entire community is being transformed by the trafficking of women for prostitution from Russia to campgrounds and villages across the border in Norway.

Political changes combined with economic crises have devastated entire world regions, increasing the supply of vulnerable women willing to risk their lives to earn money for themselves and their families. Aurora Javate de Dios, President of the Coalition Against Trafficking in Women, discusses the impact of the Southeast Asian economic crisis on women's lives in *Confronting Trafficking, Prostitution and Sexual Exploitation: The Struggle for Survival and Dignity*. Economic globalization, controlled by a handful of multinational corporations located in a few industrialized countries, continues to shift wealth from poorer to richer countries. In her paper *Globalization, Human Rights and Sexual Exploitation*, Aida F. Santos shows us the connection between global economics and the commodification and sexual exploitation of women and girls, especially in the Philippines. Structural adjustment programs implemented by international financial institutions impose loan repayment plans on poor countries, which sacrifice social and educational programs in order to service their debt to rich nations and banks. Fatoumata Sire Diakite points to structural adjustment programs as one of the factors contributing to poverty and sexual exploitation in her paper *Prostitution in Mali*. Zoraida Ramirez Rodriguez writes in *Report on Latin America* that the foreign debt and policies of the International Monetary Fund (IMF) are primary factors in creating poverty for women and children. These forces leave women with few options, increasing the supply of women vulnerable to recruitment into bride trafficking and the prostitution industry.

Social problems such as sexual and physical abuse within families force girls and women to leave in search of safety and a better life, but often they find more exploitation and violence. Physical and sexual abuse of girls and women in their families and by intimate partners destroys girls' and women's sense of self and

resiliency, making them easy targets for pimps and traffickers who prey on those who have few options left to them. These factors are evident in many of the papers from all world regions in this volume, such as Jill Leighton and Katherine DePasquale's, *A Commitment to Living* and Martha Daguno's, *Support Groups for Survivors of the Prostitution Industry in Manila*.

Government policies and practices also fuel the demand for prostitution, as they legalize prostitution or refuse to enforce laws against pimps, traffickers and male buyers. In *Making the Harm Visible*, we see how countries with governmental structures and ideological foundations as different as the Netherlands and Iran, both promote and legalize sexual violence and exploitation of girls and women. In *Legalizing Pimping, Dutch Style*, Marie-Victoire Louis exposes the liberal laws and policies that legalize prostitution and tolerate brothels in the Netherlands. On the other extreme, religious fundamentalists in Iran have legalized the sexual exploitation of girls and women in child and temporary marriages and the sexual torture of women in prison. Sarvnaz Chitsaz and Soona Samsami document this harm and violation of human rights in *Iranian Women and Girls: Victims of Exploitation and Violence*.

Global media and communication tools, such as the Internet, make access to pornography, catalogs of mail order brides, advertisements for prostitution tours and information on where and how to buy women and girls in prostitution widely available. This open advertisement normalizes and increases the demand by men for women and girls to use in these different forms of exploitation. Donna M. Hughes describes her findings on how the Internet is being used to promote the sexual exploitation of women and children in *The Internet and the Global Prostitution Industry*. In this milieu, women and girls become commodities – bought and sold locally and trafficked from one part of the world to another.

How do we make the harm of sexual exploitation visible? In a world where sexual exploitation is increasingly normalized and industrialized, what is needed to make people see the harm and act to stop it? The women in *Making the Harm Visible* recommend four ways to make the harm of sexual exploitation visible: listen to the experiences of survivors; expose the ideological constructions that hide the harm; expose the agents that profit from the sexual exploitation of women and children; and document harm and conduct research that reveals the harm and offers findings that can be used for policy initiatives.

Reprinted with permission from the Introduction to *Making the Harm Visible*, edited by D. Hughes C. Roche (1999). Kingston, RI: The Coalition Against Trafficking in Women. http://www.uri.edu/artsci/wms/hughes/mhvtoc.htm

Although gender and sexual orientation may seem intuitively to be simpler phenomena than race or ethnicity, in reality they are quite complex in terms of referring to not just biological characteristics but many aspects of psychological identity and social affiliations. Being a female or a male, let alone gay, lesbian, bisexual or transgendered means many different things to many different people. Although more stable than changeable, sexual orientation and even gender also may change for the same person over time. Thus, it is imprecise to assume that all or even most people of a given gender or sexual orientation are identical or

even similar without careful and objective assessment of how they view themselves and how they actually act, think and feel.

In relationship to psychological trauma and PTSD, therefore, the broad generalizations that have been suggested by research concerning gender and sexual orientation relate more to the way in which people of a gender or sexual orientation are generally viewed and treated (which varies depending upon the society and culture) than to inherent qualities of a given gender or sexual orientation (which is highly individual across all societies and cultures). The finding that girls and women are more often subjected to sexual and intrafamilial traumatic stressors while boys and men more often experience accidental, combat and assaultive traumatic stressors, is consistent with stereotypic sex roles that are found in many (but not all) cultures which assign females to the role of subservient caregiver while males are assigned to the role of hunter and warrior. There are biological foundations for these differences – such as due to distinct levels of the sex-linked hormones estrogen and testosterone and brain chemicals that differentially affect females and males (oxytocin and vasopressin; see Chapter 5). However, biology need not dictate a person's or a group's destiny, so it is inaccurate to assume that males or females must always fill these sex role stereotypes, particularly when there are severe adverse consequences such as the epidemics of abuse of girls and women and of boys and men killed as violent combatants.

Stereotypes can be even more insidious and damaging in relation to sexual orientation. Only in the past three decades has homosexuality been rescued from the status of a psychiatric disorder (as it was in the first three editions of the *Diagnostic and Statistical Manual*). Stigma and harassment evidently are still experienced, potentially with traumatic results when violent acts are tolerated or even encouraged, by GLBT adults and youths. It is not surprising that the prevalence of PTSD is greater among persons with other than heterosexual sexual identities and the extent to which this is the result of the pernicious stigma directed at such individuals in most cultures, or of outright traumatic violence, or both, remains to be tested.

PHYSICAL AND DEVELOPMENTAL DISABILITIES AND PTSD

Persons with physical or developmental disabilities are another group of persons who unfortunately may be subjected to stigma and discrimination. Physical disabilities are more common in developing countries than in more industrialized and affluent nations in which medical technology and accident and illness prevention have reduced the risk of severe injury or genetically-based physical disabilities (Mueser et al., 2003). Persons with physical disabilities may be at risk for exposure to traumatic accidents or maltreatment as children and as adults due to limitations in their abilities to care for themselves and live independently, particularly if they have cognitive impairment due to conditions such as mental retardation or serious mental illness.

Only one study that examined the prevalence of exposure to potentially traumatic events among physically disabled persons could be located. That was a national survey of women with physical disabilities by the Center for Research

on Women with Disabilities (Nosek et al., 1999; http://www.bcm.edu/crowd/national_study/INTRODUC.htm). On the one hand, the study found that disabled women were no more likely to report exposure to physical or sexual abuse than women without physical disabilities. However, in more detailed interviews with a sub-sample, more than 80% reported instances of abuse, on average two incidents per woman (each often lasting for a lengthy time period). For example, the report provides verbatim quotations:

> My mother wasn't around much and I always felt in my sisters' way, like I held them back from things they wanted because they had to help care for me. My sisters would slap me and shut me in my room.
>
> *32-year-old woman with congenital osteogenesis imperfecta*

> After my child was born, my husband became jealous and didn't want me to get up and take care of her. He would take my chair away from me and tied me up when I pulled myself out of bed. I left him the first chance I had.
>
> *49-year-old woman with spinal cord injury since age 17*

More than half of all respondents (52% with disabilities, 51% with no disability) reported a history of either physical or sexual abuse or both, which is a substantially higher prevalence than that reported in epidemiological surveys of nationally representative samples of women. Notably, women with disabilities were more likely than women without disability to report emotional abuse from a caregiver or family member and to have experienced all forms of abuse for a longer time period than women without disability. Although PTSD was not assessed, women younger than 50 years old with spina bifida (39%), amputation, traumatic brain injury or multiple sclerosis (>25%) were highly likely to be diagnosed with depression than women with no disability. In light of the extensive histories of potentially traumatic abuse and of depression, it appears that women with physical disabilities – particularly those in early to midlife adulthood with disabilities that involve progressive deterioration or mental or psychological disfiguration – may be at risk for having experienced traumatic abuse and suffering from undetected PTSD.

Traumatic brain injury (TBI) is a special case of physical disability because it involves physical injury that specifically compromises mental functioning. TBI ranges from mild (no more than 30 minutes of unconsciousness and 24 hours of amnesia) to severe (coma of at least six hours or amnesia for more than 24 hours). Studies with adults and children of both genders who have sustained TBI demonstrate that they are as likely to develop PTSD as persons in equally severe accidents or assaults who do not sustain TBI (McMillan et al., 2003). Fewer studies have been conducted with persons with severe than mild TBI, but they have not been found to be *less* likely to develop PTSD as was originally hypothesized – due to not being able to experience or later recall the psychologically traumatic aspects of the injury as vividly as a person who does not lose consciousness or have amnesia. A subsequent study confirmed that adults with TBI were less likely to report acute traumatic stress symptoms immediately after the injury and to recall having felt helpless when interviewed several weeks later, but that three months after the accident they were equally likely to report PTSD symptoms as injury survivors with no TBI (Jones et al., 2005). Thus, PTSD warrants

careful assessment when TBI has occurred, although it is no more likely than if TBI did not occur (McMillan et al., 2003).

Concerning developmental disabilities, similarly, only one published study of PTSD could be located (Ryan, 1994). In that study, 51 adults receiving services for learning disability were more likely than other adults (Kessler et al., 1995) to report exposure to traumatic stressors (100% prevalence, on average two past traumatic events). However, they had no greater risk of PTSD than adults in the general population when exposed to traumatic stressors. The most frequently reported types of traumatic exposures were sexual abuse by multiple perpetrators (commonly starting in childhood), physical abuse or life-threatening neglect. Traumatic losses involving a caregiver or close relative or friend, including witnessing the death in several instances (such as witnessing a sibling dying in a fire, a close friend die during a seizure or an accident or a parent commit suicide by shooting himself in the head with a gun) also were reported by at least 10% of the participants. Most of the learning disabled adults who met criteria for PTSD had been referred for treatment for violent or disruptive behavior, typically with no psychiatric diagnosis or a diagnosis of schizophrenia, autism or intermittent explosive disorder. When PTSD was diagnosed, major depression was a frequent comorbid disorder. Neither PTSD nor depression typically had been identified prior to the clinical assessment study. This study suggests that adults with developmental disorders often may have been targets for abuse or neglect in childhood, as well as 'sustaining severe traumatic losses' and that their behavioral difficulties tend to be the focus of services rather than the potentially more fundamental problems of PTSD and depression (see Box 11.2).

BOX 11.2 Developmental Disabilities and PTSD: Case Studies

Two cases taken from McCarthy (2001) show the adverse impact of undetected PTSD: 'A 15-year-old girl with learning disability has suffered early abuse of a physical and sexual nature, including neglect. She presented [for medical evaluation] in early childhood with behavioural problems of aggression. She settled in a residential school from age 12–13 before an act of arson. She later revealed that she had experienced inappropriate sexual behaviours with peers at school. She complained of intrusive thoughts and images, along with depressive symptoms. At times she shows sexually inappropriate behaviour and self-harm.'

'A 40-year-old man with moderate learning disability who had been sexually assaulted by a care[giver] presented [for medical evaluation] in [an] acute state with disturbance of appetite, sleep, loss of skills and emotional numbness, but the abuse was revealed only months later. On being exposed to the perpetrator at a later date he showed a deterioration in mental state with acute symptoms of anxiety, and later developed a depressive disorder requiring medication. His level of functioning never returned to that prior to the traumatic event.'

A third case illustrates the therapeutic gains that a PTSD perspective can provide:

A thirty-two-year-old woman with learning disabilities and pervasive developmental disorder had been diagnosed at age eleven with schizophrenia and subsequently had

been diagnosed with schizoaffective disorder, bipolar disorder and borderline personality disorder. For twenty years after the first psychiatric diagnosis and hospitalization, she had been psychiatrically hospitalized more than fifty times due to episodes of acute suicidality complicated by auditory command hallucinations (i.e. she believed she was hearing voices telling her to kill herself) and compulsive self-harm behavior (she used sharp objects to cut virtually every area on both arms and legs). Treatment included high doses of antipsychotic, antiseizure, antidepressant and anti-anxiety medications and two courses of electroconvulsive therapy (ECT), with periods of relative stabilization sufficient for her to live in an assisted living residential home and on two occasions to live in an independent apartment with in-home daily case management and nursing care. Each period of improvement was relatively brief, lasting no longer than 3–6 months at which time she experienced severe worsening in the apparently psychotic, depressive and anxiety symptoms requiring multiple re-hospitalizations and progressive loss of social and cognitive abilities. For several years, family therapy was conducted and the patient's history of traumatic stressors was assessed gradually in order not to lead to further destabilization. In addition to potential episodes of sexual assault as an adolescent and young adult, her mother disclosed that her biological father had been severely domestically violent during the patient's first two years of life, until the mother ended that relationship. When PTSD was confirmed and accepted by the treatment team and the patient and her family as the primary diagnosis, the patient felt that she finally understood why she was experiencing the cyclic surges in distress and was able to utilize affect regulation skills (taught using dialectic behavior therapy and trauma affect regulation: guide for education and therapy, see Chapter 7). Over the next year, her medications were carefully reduced to the lower therapeutic range for attentional problems and anxiety, with a sustained improvement in mood and social and cognitive functioning such that she was able successfully to work as a skilled volunteer in an assisted living center for older adults.

The first two case vignettes are reprinted with permission from McCarthy (2001, p. 167)

POVERTY, PSYCHOLOGICAL TRAUMA AND PTSD

Poverty is an adverse result of having low 'social status'. This does not mean that a person or group is objectively deficient, but rather that they are identified socially and politically as either not deserving or not possessing the social mandate to have access to resources such as money, safety, housing, transportation, healthcare, education and gainful employment. Kubiak's (2005) social location theory states that each individual possesses identities within their society that are defined by factors such as their race, socioeconomic class, gender, age, residential status and legal status. The greater the number of oppressed identities that one possesses the more likely one will be 'poor', including not only low income but also living in neighborhoods plagued with high crime, gang violence, abandoned buildings, drugs, teen pregnancy, high unemployment rate, underfunded schools, housing shortage and unresponsive police. Thus, poverty fundamentally is a breakdown of the social order as well as a resultant deprivation of resources for some people.

The relationship between low income and exposure to psychological trauma and PTSD has been studied primarily in relationship to women and families, including those who currently have stable housing and those who are homeless. Morrell-Bellai and colleagues (2000) identify poverty as a core risk factor for homelessness, because the socioeconomic benefits provided by a diminishing societal safety net and the typically insufficient employment wages provided by marginal jobs force people to rely on an increasingly limited pool of subsidized housing or else become homeless. Associated risk factors include a lack of education, lack of work skill, physical or mental disability, substance abuse problem, minority status, sole support parent status or the absence of an economically viable support system (Fischer and Breakey, 1991; Morrell-Bellai et al., 2000). Snow and Anderson (1993) found that the most common reasons for homelessness reported in a survey of men and women living 'on the street' were family related problems such as: marital break-up; family caregivers becoming unwilling or unable to care for a mentally ill or substance abusing family member; escape from a dysfunctional family; or not having a family to turn to for support.

Poverty and homelessness involve a vicious cycle in which socioeconomic adversities are compounded by the experience of homelessness, leading to psychological disaffiliation, hopelessness and loss of self-efficacy (Hopper and Baumohl, 1994; Bentley, 1997; Morrell-Bellai et al., 2000) – which thus tends to perpetuate poverty and homelessness. A recent study by Ford and Frisman (2002) reported that 91% of a sample of very low-income homeless women caring for children had experienced at least one type (and on average, five different types) of psychologically traumatic events, usually repeatedly and over long periods of time, with one in three having experienced full or partial PTSD at some time in their lives. In addition, Ford and Frisman (2002) found that one in three of these homeless women with children had experienced a complex variant of PTSD involving problems with dysregulated affect or impulses, dissociation, somatization and alterations in fundamental beliefs about self, relationships and the future (i.e. 'complex PTSD' or 'disorders of extreme stress'; Ford, 1999). More than half of the sample had a history of either or both PTSD and its complex variant.

Exposure to violence and other forms of victimization begins in childhood for many homeless individuals, in part due to living in economically impoverished families (North et al., 1994). Rates of childhood physical abuse as high as 52% among homeless adolescents have been reported (MacLean et al., 1999). Extremely poor women, whether homeless or not, have elevated rates of lifetime PTSD or other mental illness and a history of such disorders is associated with having grown up in family environments with violence, threat and anger (Davies-Netzley et al., 1996; Bassuk et al., 2001). However, homelessness *per se* may confer additional risk: homeless mothers have higher lifetime rates of violent abuse and assault than equally impoverished housed mothers (Bassuk et al., 1998). Thus, poverty puts people at risk for traumatic violence, but not having a stable residence compounds this risk and the likelihood of developing PTSD.

VICTIMS OF POLITICAL REPRESSION, GENOCIDE ('ETHNIC CLEANSING') AND TORTURE

When political power is used to repress free speech and citizens' self-determination, there is an increase in the risk to members of that nation or community and its neighbors and associates of psychological trauma. Domestic violence (see Box 10.2) is a microcosm that shares much in common with large-scale political repression, because physical, psychological and economic power is used to entrap, systematically break down and coercively control the thoughts as well as the actions and relationships of the victim. On a larger scale, political repression involves similar psychological (and often physical as well) assaults by the people and institutions in power on the people, families, communities and organizations who are deprived of access to political power and socioeconomic resources and, therefore, also on their fundamental freedoms and values. Without access to self-determination and the resources necessary to sustain independence, people are vulnerable to not just traumatic exploitation and violence but also to the traumatic loss of their intimate relationships, their families, their way of life and their values (see Box 11.3).

Genocide (also described as 'ethnic cleansing') is an attempt to use hardship and violence to eliminate an entire collectivity of people. Historically, genocide has occurred often when conquering nations not only dominated and subjugated other nations but sought to eradicate their core culture and kill off or enslave the entire population. Examples in the 20th century include the Armenian genocide in Turkey, the Holocaust inflicted on Jewish people in Europe by the Nazis, the 'ethnic cleansing' in Bosnia and Serbo-Croatia in the 1980s and the massacres and mass starvation and epidemics perpetrated in Rwanda in 1994, in Sudan beginning in 2003 and in Somalia, Kenya and Zimbabwe most recently. 'Genocide' was first used as a term in 1944 by Raphael Lemkin, combining the word '*genos*' Greek for race or kind and '*cidere*', which is Latin and can be translated as 'kill' (Brom et al., 2008). In 1948, the term was adopted by the United Nations General Assembly and defined by the United Nations Convention on the Prevention and Punishment of the Crime of Genocide (CPPCG) as follows:

> . . .any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:
>
> (a) Killing members of the group
> (b) Causing serious bodily or mental harm to members of the group
> (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part
> (d) Imposing measures intended to prevent births within the group
> (e) Forcibly transferring children of the group to another group. (http://www.unhchr.ch/html/menu3/b/p_genoci.htm)

Gregory Stanton, the president of *Genocide Watch,* described '8 Stages of Genocide':

1. Classification – earliest stage, dividing people into 'us' and 'them' (the victim group)

BOX 11.3 The Lost Boys of Sudan: Complex PTSD in the Wake of Societal Breakdown

In the book, *What is the What?* by Dave Eggers (2006), Valentino Achak Deng (a fictional character based upon a real person) tells an autobiography that includes trials and tribulations in his current home in Atlanta, Georgia and a traumatic journey of many years as a 'lost boy' fleeing from his large family's home in a rural village in Southern Sudan to refugee camps in Ethiopia and Kenya. Valentino graphically describes a relentless series of traumatic experiences that include his village becoming a warzone, the deaths of family and friends, starvation and continual threats of being killed while traveling by foot with thousands of other 'lost' children to escape Sudan, witnessing brutal acts of violence by children as well as adults (e.g. a boy beating another boy to death in a fight over food rations) and being robbed and beaten unconscious in his own home in Atlanta by a predatory African American couple.

Valentino is a good example of a person who suffers from chronic and complex PTSD yet is extremely articulate, intelligent and resourceful. Valentino struggles with both unwanted memories and the need to keep his memories so that he ultimately can make sense of what has happened to him: 'What is the What?' By writing his autobiography he did what the therapy for children or adults with PTSD is intended to do: making sense of, rather than attempting to avoid, memories and reminders of traumatic experiences as a part – albeit horrible or tragic – of one's complete life story (see Chapters 7 and 8). For example, in trauma focused cognitive behavior therapy, the therapist helps the child to write (or in other creative ways to depict, such as by drawing pictures, using puppets, dolls or action figures or using collage or music) a 'story' of what happened to them before, during, and after traumatic experience(s) and to share this 'story' with a parent who can help the child with feelings of guilt and fear so that the traumatic memory can be 'over' in the child's mind. Because Valentino was not able to get that kind of help, his autobiography as an adult (the book) is a kind of second attempt to achieve a sense of resolution by telling his story. But we see how this is very difficult to do when current life involves new problems and dangers that interfere with achieving a sense of safety. Whether Valentino succeeds in achieving some degree of emotional resolution about what he and his loved ones have suffered is an open question. What is clear is that he never stops trying to do so.

It also is apparent that Valentino's ethnic identification and heritage as an African man from the Dinka tribe is very important as a protective factor enabling him to retain a small but significant fragment of his sense of personal identity and his intimate ties to his family and community. He experiences an odyssey as a victim fleeing the scene of horrific trauma, an initially reluctant but eventually drug-induced savage combatant and a refugee 'stranger in a strange land' when he is able to escape to what seems like an entirely different planet in the cosmopolitan urban setting of Atlanta and the southern USA. It is the psychological trauma that he experiences on this odyssey and the chronic stressors and societal breakdown and oppression that led him – and millions of others of all ages and a multiplicity of ethnocultural groups – on this journey of crisis and survival and not his ethnicity or cultural background, that is responsible for the profound symptoms of PTSD that he develops.

2. Symbolization – assigning particular symbols to designate the victim group members
3. Dehumanization – equating certain people with sub-human animals, vermin or insects
4. Organization – militias or special units created for the purpose of genocide
5. Polarization – broadcasting of propaganda aimed at marginalizing the out-group
6. Preparation – out-group members are physically separated or confined in a 'ghetto'
7. Extermination – murder, starvation, infection or other forms of inflicting pain and death
8. Denial – refusal to accept responsibility or admit wrongdoing, maintaining the self-righteous position that the victim group deserved annihilation and were sub-human.

These stages are approximate and vary in each separate incident, but they demonstrate how genocide differs from other forms of even very horrific violence (such as war) because the aim is not simply to subdue, harm or exploit but to dehumanize, exterminate and annihilate. Genocide thus involves several traumatic features, including loss of self-worth and allegiance to core values and institutions, prolonged pain and suffering, bereavement, terror and horror of annihilation, injury, helplessness while witnessing demeaning, cruel and violent events and confinement.

Survival responses to genocide are described by Brom & Pat-Horenczyk, (2008) as:

> a narrowing of functioning and awareness in order to maximize the chances of survival [often involving] psychic closing off (also called robotization, that is, acting and feeling emotionally and mentally empty or on 'automatic pilot' like a 'robot') [and] regression, that is, feeling, thinking, and acting like a child (or in the case of children, like a much younger age than their actual chronological age). Often victims also experience a strong dependence on perpetrators who decide on life and death. The 'muselman effect' . . . manifested by complete physical decrepitude, apathy, slowing of movement and gradual disintegration of personality (including loss of the capacity for rational reasoning) may result when individuals have been exposed to long-term and extreme circumstances. An additional phenomenon that is well documented is the so-called 'death imprint' resulting when substantial witnessing of death continues to haunt the survivor.

These reactions closely parallel the symptoms of both acute stress disorder (such as dissociation and regression) and PTSD (such as intrusive re-experiencing and emotional numbing). The adverse long-term effects of experiencing genocide are severe and pervasive. More than one in three survivors become clinically depressed and develop PTSD. The social support of caring family members (and for children, parents or other caregivers) and relationships and activities that enable the person to retain their spiritual or religious beliefs and their sense of self-respect, are crucial protective factors against PTSD and depression. However, even the most resilient and socially supported person is likely to experience distressing memories and survivor guilt years or even decades later. Studies with elderly Holocaust survivors who are physically and emotionally very hardy

(often well into their 80s and 90s) have documented significant persisting emotional distress and PTSD symptoms 60 or more years later (Brom et al., 2008). Moreover, the offspring of Holocaust survivors with PTSD are more likely than offspring whose parents do not have PTSD to experience PTSD themselves as adults (Yehuda et al., 2000).

Genocide often involves physical hardships that compromise physical health and may lead to long-term illnesses and depletion of the body's immune system. For example, the physical exertion and pain involved in torture, untreated physical illnesses, insufficient sleep, starvation, exposure to extreme temperatures and forced labor may accelerate the aging process (Brom et al., 2008). Genocide also often includes separating families and community groups. This not only deprives the survivor of crucial social support but engenders a sense of isolation, distrust and shame and being permanently psychologically damaged (Herman, 1992b). Survivors also are faced with a choice of holding to their allegiance to their family, nation, culture and racial identity despite the punishment inflicted by the perpetrators or abandoning these basic commitments and rejecting themselves and people like them. Faced with this impossible choice (as epitomized in William Styron's classic novel, *Sophie's Choice*), survivors often believe that they failed utterly and let down not only themselves but their family and culture *no matter how resiliently they coped and the integrity of their efforts*. Survivor guilt is an expression of a sense of grief, powerlessness and failure, including questioning why they survived and others did not.

Torture

Torture is a terrible special case of political repression that involves 'malicious intent and a total disregard for the recipient's dignity and humanity. Thus, torture is among the most egregious violations of a person's fundamental right to personal integrity and a pathological form of human interaction' (Quiroga and Jaranson, 2008).

The 1984 United Nations (UN) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), is endorsed by 210 nations and defines torture as:

> For the purpose of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions. (*http://www2.ohchr.org/english/law/cat.htm*)

An Amnesty International 2000 worldwide survey found that 75% of countries practice torture systematically, despite its absolute prohibition of torture and cruel and inhuman treatment under international law. Torture may be euphemistically referred to as 'enhanced interrogation techniques' and condoned

in order to obtain 'intelligence' from designated enemies of the nation, although this is completely prohibited by the UN resolution (Quiroga and Jaranson, 2008). Basoglu et al. (2007), in a sample from the Balkan War (1991–2001) studied from 2000 to 2002, showed that the torture need not inflict physical pain in order to produce PTSD.

Psychological assessment of torture survivors was systematized by the Istanbul Protocol, a manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment that includes modules for medical, psychological and legal professionals, United Nations resolution 55/89 on December 4, 2000 (Quiroga and Jaranson, 2008).

The psychological problems most often reported by torture survivors are emotional symptoms (anxiety, depression, irritability/aggressiveness, emotional liability, self isolation, withdrawal); cognitive symptoms (confusion/disorientation; memory and concentration impairments); and neurovegetative symptoms (lack of energy, insomnia, nightmares, sexual dysfunction) (Quiroga and Jaranson, 2008). The most frequent psychiatric diagnoses are PTSD and major depression, other anxiety disorders such as panic disorder and generalized anxiety disorder and substance use disorders. Longer-term effects include changes in personality or worldview, consistent with complex PTSD (Quiroga and Jaranson, 2008). The greater the degree of distress and loss of sense of control during torture, the greater the likelihood of PTSD and depression. Resilience, through being able maintain a sense of personal control, efficacy and hope while enduring torture, is associated with less distress during torture and lower risk of PTSD (Quiroga and Jaranson, 2008).

However, Quiroga and Jaranson (2008) cite an unpublished Swedish study by Olsen showing that 10 years after torture, physical pain was still prevalent even if torture was primarily psychological in nature. Based on this finding and related studies, they conclude that:

> the most important physical consequence of torture is chronic, long-lasting pain experienced in multiple areas of the body. All [physical] torture victims show some acute injuries, sometimes temporary, such as bruises, hematomas, lacerations, cuts, burns, and fractures of teeth or bones, if examined soon after the torture episode. Permanent lesions, such as skin scars on different parts of the body, have been found in 40% to 70% of torture victims. . . . Falanga, beating the sole of the feet with a wooden or metallic baton, has been studied extensively. Survivors complain of chronic pain, a burning sensation. . . . Acute renal failure secondary to rhabdomyolysis, or destruction of skeletal muscle, is a possible consequence of severe beating involving damage to muscle tissue. This condition can be fatal without hemodialysis . . . A severe traumatic brain injury that is caused by a blow or jolt to the head or a penetrating head injury may disrupt the function of the brain by causing a fracture of the skull, brain hemorrhage, brain edema, seizures, and dementia. The effects of less severe brain injury have not been well studied. Damage to peripheral nerves has been documented in cases where victims have been suspended by their arms or tightly handcuffed . . .

Treatment for torture survivors must be multidisciplinary and a long-term approach. Several treatment approaches have been developed, but little consensus

exists concerning the standard of practice and treatment effectiveness has not been scientifically validated by treatment outcome studies (Quiroga and Jaranson, 2008). A key element that is widely agreed upon is to pay careful attention not to replicate inadvertently aspects of torture in benign ways in treatment (such as by pressing a survivor to recount traumatic memories without the survivor's informed and voluntary consent; or by encouraging or discouraging political, family and social activities except as initiated by the survivor). It also is best to use medical, psychiatric medication and psychotherapy modalities to address the PTSD symptoms of impaired sleep, nightmares, hyperarousal, startle reactions and irritability. Quiroga and Jaranson (2008) also recommend using groups for socializing and supportive activities to re-establish a sense of family and cultural values and supporting the traditional religious and cultural beliefs of the survivor.

Currently, nearly 250 torture survivor treatment centers have been identified worldwide, 134 of them accredited by the International Rehabilitation Council of Torture Victims (Quiroga and Jaranson, 2008). Most of these centers also involve the survivors' families and communities in developing shared approaches to recovery and reparation of the harm done to them all.

Recent controversy concerning the use of torture on detainees in the so-called 'war on terror' has led to deep concern on the part of not only the public at large but specifically by mental health professionals. The issue is that psychiatry and psychology professionals who are in the military or consult to the military have been involved in the detention and interrogation of suspected terrorists at high security facilities such as the military base at Guantanamo Bay and the military prison in Iraq, Abu Ghraib. As a result, guidelines for mental health professionals working in these or similar facilities in which prolonged detention and interrogation may involve practices that constitute torture have been developed by a special committee of the American Psychological Association's Division (56) on Trauma Psychology (see Box 11.4).

BOX 11.4 Excerpts from: The American Psychological Association Division 56 Task Force Examining Psychologists' Role in Interrogation from the Perspective of Trauma

The involvement of psychologists in national security interrogations in places like Abu Ghraib, Guantanamo Bay, CIA black sites and other undisclosed secret prisons has become a matter of considerable controversy. The issue has not only been addressed in the popular media as evidenced by articles in venues such as *The New York Times*, *Vanity Fair*, *The New Yorker* and *Psychology Today* but it has also received widespread attention in diverse professional publications such as the *Journal of the American Medical Association*, *New England Journal of Medicine*, *The Lancet*, *British Medical Journal*, *Journal of Psychiatry Law*, *Psychiatric News*, *Military Medicine*, *The Chronicle of Higher Education* and *Congressional Quarterly*.

The APA Council of Representatives included in its 'unequivocal condemnation' all techniques considered torture or cruel,

inhuman or degrading treatment or punishment under the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; the Geneva Conventions; the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; the Basic Principles for the Treatment of Prisoners, the McCain Amendment, the United Nations Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment an 'absolute prohibition against mock executions; waterboarding or any other form of simulated drowning or suffocation; sexual humiliation; rape; cultural or religious humiliation; exploitation of fears, phobias or psychopathology; induced hypothermia; the use of psychotropic drugs or mind-altering substances; hooding; forced nakedness; stress positions; the use of dogs to threaten or intimidate; physical assault including slapping or shaking; exposure to extreme heat or cold; threats of harm or death; isolation; sensory deprivation and over-stimulation; sleep deprivation; or the threat [of these] to an individual or to members of an individual's family. Psychologists are absolutely prohibited from knowingly planning, designing, participating in or assisting in the use of all condemned techniques at any time and may not enlist others to employ these techniques . . .'

We have come to the conclusion that the USA's harsh interrogation-detention program is potentially trauma-inducing both in general (e.g. indefinite detention, little contact with lawyers, no contact with relatives or significant others, prolonged absence of due process, awareness that other prisoners have been tortured, lack of predictability or control regarding potential threats to survival or bodily integrity) and in terms of some of its specific components (e.g. prolonged isolation, waterboarding, humiliation, painful stress positions). In other words, these potentials for trauma extend beyond the narrow procedures that meet international definitions of torture. The evidence for risk of psychological trauma to detained enemy combatants is particularly compelling and well-grounded in formal research but there is also suggestive anecdotal and theoretical evidence of trauma induction in interrogators and the broader society. We were particularly struck by the fact that the potentially traumatic elements include not only activities designed to extract information from prisoners but also much of the detention process as it is currently conceived, beyond much oversight, or compliance with international law. Given the pervasiveness of these traumatogenic elements, it is questionable whether psychologists can function in these settings without participating in, or being adversely affected by, heightened risk for trauma. Nonetheless, as a group of psychologists with expertise in preventing traumatic stress and ameliorating debilitating post-traumatic sequelae, we believe that certain steps could minimize the risk of psychological trauma. They are as follows:

1. We believe that the risk of traumatic stress and negative posttraumatic sequelae will be reduced if psychologists adhere to both the APA *Ethical Standards* and subsequent refinements of APA policies pertaining to interrogation, detention and torture. Such adherence would be more likely if the APA ethics code were revised to incorporate, as enforceable standards, the specific interrogation and torture-related policy refinements that have occurred since 2002.

2. Psychologists should promote situations that maintain the risk of traumatic stress at acceptably low levels and avoid situations that heighten the risk for traumatic stress occurring. Among other things, this means that psychologists should not provide professional services in secret prisons that appear to be beyond the reach of normal standards of international law or in settings in which torture and other human rights abuses have been credibly documented to be permitted on the basis of local laws. It also suggests that psychologists should not support or participate in any detention or interrogation procedure that constitutes cruel or inhumane treatment or that otherwise has been shown to elevate risk of traumatic stress (e.g. prolonged isolation).
3. If psychologists work in settings in which detention and interrogations are conducted then they should conduct or seek an assessment of the potential traumatic features of the treatment of detainees before, during and after interrogation. This assessment can be informal or formal depending upon whether other systems of oversight are in place. This assessment should include an examination of the social psychological factors that could elevate risk of trauma. Because not all psychologists have expertise in assessing traumatic stress risk and/or social psychological factors, the assessment should be conducted by psychologists who have this specific expertise. Such assessments could inform decisions not only by psychologists but also by others working in facilities in which detention and interrogation occur. It is recommended therefore that APA advocate for appropriate governmental authorities to appoint an independent oversight committee for each facility of this type and that the oversight committees include psychologists identified by APA as having relevant expertise.
4. If psychologists work in settings in which risk of traumatic stress is found to be elevated then they should: (a) formally recommend alterations that could reduce the traumatogenic potential of the detention and interrogation process (NB: some recommendations may be aimed at policy-makers rather than local authorities); (b) conduct or seek an assessment of posttraumatic stress symptoms and associated features (e.g. depression, dissociation, etc.) in detainees, interrogators and other directly or indirectly involved staff; (c) recommend appropriate psychological interventions for any detainees or personnel found to be suffering from clinically significant psychological difficulties; and (d) refuse to participate in any activities that significantly increase risk of traumatic stress. If a psychologist working in such settings does not have specific expertise required to meet some of the above recommendations then she or he should consult with psychologist(s) who have this expertise to make the appropriate determination.
5. Because some detainee abuses have been credibly linked to an absence of appropriate training and/or expertise, psychologists should advocate for, participate in designing and/or assist with providing appropriate and comprehensive training to all personnel involved in interacting with detainees. This training should include: (a) clear ethical guidelines emphasizing the

prohibition of causing harm and the importance of protecting detainee rights; (b) a research-based overview of the nature and consequences of traumatic stress and posttraumatic impairment as they relate to the interrogation and confinement process and all parties involved in layperson terms with practical implications; and (c) detailed review of research on false confessions, in layperson terms with practical implications for enhancing the validity and utility of information gathered in the course of interrogation and detention. Because not all psychologists have expertise in these specific matters, APA should develop standardized training materials that cover the current state of psychological knowledge and practices on these important topics and ensure that these materials are regularly updated by qualified psychologists in consultation with experts from other fields such as law enforcement, the military, and human rights.

6. Because protecting human rights reduces the risk for traumatic stress and posttraumatic impairment, psychologists should collaborate with legal, military and other colleagues to advocate for due process for all detainees including providing clear guidelines about finite lengths of detention prior to formal hearing or trial and enforcing the recent Supreme Court decision to reinstate habeas corpus and other international standards of human rights. Psychologists' support for these actions should not come from a blanket support for adherence to law but rather from an informed judgment that these laws reduce the risk for harm. Psychologists should be prepared to disagree with any future international laws or US Supreme Court decisions that heighten risk for traumatic stress.
7. Psychologists should support increased transparency during the detention and interrogation process. Such increased transparency could reduce the likelihood of traumatizing practices, increase the likelihood that traumatizing practices will be identified and stopped as early as possible and protect ethical psychologists and other workers within the system from being falsely accused of acting unethically. We recognize that this recommendation raises an apparent conflict with the goal of secrecy commonly endorsed by national security organizations. We concur that full transparency is unreasonable and counterproductive. Yet, we do believe that increased transparency is a safeguard against traumatizing practices. Though the details of resolving this conflict are beyond the scope of this task force's expertise, we believe that reasonable, knowledgeable intelligence experts, in consultation with psychologists, can construct a system of oversight that will both retain credible independence from the military chain of command and guard classified information. One suggestion may be to establish a greater presence of psychological expertise within a framework of oversight protection.
8. If psychologists are going to continue to be involved in interrogations then it will be important to continue to segregate the function of interrogation consultant from that of mental health provider to reduce risk of perceived or actual betrayal by the detainee. It is unknown whether betrayal of trust due to dual roles can constitute a

direct form of traumatization under these circumstances, but it is likely that betrayal in this context could exacerbate traumatic stress that occurs of other aspects of detention and interrogation (especially in light of the ways that such detention appears to disrupt attachment as outlined in the body of our report). Maintaining separate roles also may enable the psychologist more effectively to assist detainees with traumatic stress reactions by fostering a trusting therapeutic relationship.

9. Psychologists should advocate for extra protections for detainees who are from vulnerable populations such as minors, ethnic minorities or other groups that have limited access to socioeconomic or political resources or are potentially subject to societal discrimination or prejudice because such groups may be more likely to receive coercive interrogations and/or excessive force and less likely to be sympathetically viewed by the general public. For this purpose, psychologists may work within sponsor/authorizing organizations to institute developmental, gender and culture sensitivity trainings for interrogators and should review evidence concerning the impact of different forms of traumatic stressors and differential sensitivity to the interrogation/detention setting/process on different (and particularly vulnerable) ages, genders and cultural backgrounds. Such psychologists should, to whatever extent possible, guard against such information being used to exploit vulnerable populations and instead emphasize ways to enhance safety and psychological well-being in the interrogation process. If psychologists lack relevant expertise to meet the recommendations, they should seek or advocate for outside expert consultation.
10. Psychologists should collaborate with colleagues from a variety of professions and organizations, including the military and intelligence organizations to conduct ethical research on several aspects of the detention and interrogation process especially its potential for inducing trauma. Recent reviews suggest that most of the interrogation procedures used today have not received recent rigorous study (Intelligence Science Board, 2006). Furthermore, very little of the recent study has been directed towards understanding the psychological effects of interrogation on not only the detainees but also the people working within and outside the interrogation and detention system.

REFUGEE SURVIVORS OF POLITICAL VIOLENCE AND CATASTROPHIC DISASTERS

Political violence not only leads to traumatic harm to people while they are living in their communities, but also often when victims are forced to flee their homes either to another country or while remaining within their country. Refugees are defined by the United Nations High Commissioner for Refugees (UNHCR) as persons who have left their nation of origin to escape violence (www.unhcr.org). Article one of the 1951 United Nations Convention Relating to the Status of Refugees defines a refugee as someone who, 'owing to well-founded fear of being

persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it' (UN High Commissioner for Refugees, 1951, p. 16).

Therefore, refugees are distinct from both legal and illegal immigrants, economic migrants, environmental migrants and labor migrants (Weine, 2008). Refugees must involuntarily leave home, community and often family and friends, often with limited resources or preparation and usually without knowing whom they can trust and where they can find a safe haven. Thus, both prior to and during the displacement, refugees often suffer psychologically traumatic experiences including having their community or homes attacked due to war, racially or ethnically-targeted genocide or terrorism, institutionally-orchestrated deprivation and violence, torture, atrocities, rape, witnessing violence, fear for their lives, hunger, lack of adequate shelter, separation from loved ones and destruction and loss of property (Weine, 2008).

Estimating the number of refugees is very difficult. A minimum estimate that is probably much lower than the actual number is calculated by the United Nations based on the number of persons in re-settlement camps or individually recognized by a host country. Based on this definition, there were 16 million refugees worldwide in 2007 (www.unhcr.org) (see Figure 11.1).

Most reside in neighboring countries, fleeing from conflict-torn places such as Burundi, Congo, Somalia and Sudan in Africa, Palestine and Iraq in the Middle East, Afghanistan, China, Nepal, Myanmar and Malaysia in Asia, Colombia in South America and the Balkans and Russian federation. Others seek asylum in or immigrate to Western countries in Europe and America.

Many people displaced from their communities by violence remain in their country. They are not considered refugees, but 'internally displaced persons' (IDP), 'people or groups . . . who have been forced to leave their homes' due to 'armed conflict, situations of generalized violence, violations of human rights, or natural- or human-made disasters, and who have not crossed an international border' (www.unhcr.org). As of 2007, there were more three times as many IDPs as refugees, an estimated 51 million worldwide, 26 million due to armed conflict and 25 million due to mass natural disasters (www.unhcr.org). Between one and more than three million IDPs were known to be in several countries in 2007, including Colombia, Congo, Iraq, Somalia, Sudan and Uganda. Azerbaijan, Cote du N'Orde, and Sri Lanka had more than 500 000 known IDPs each.

At least another three million persons are considered 'stateless', i.e. not to be citizens of any nation, in 2007. Nepal and Bangaladesh have the majority of the stateless persons in the world, although nearly three million persons in those two countries were made citizens in 2007. Palestine and Iraq are the other countries with large numbers of stateless persons. There may be millions more stateless individuals, because only 54 countries assisted the United Nations in its census of stateless persons in 2007 (www.unhcr.org).

The impact of forced displacement often is not just extremely stressful but traumatic. Refugees, IDPs and stateless persons have few protections and often must

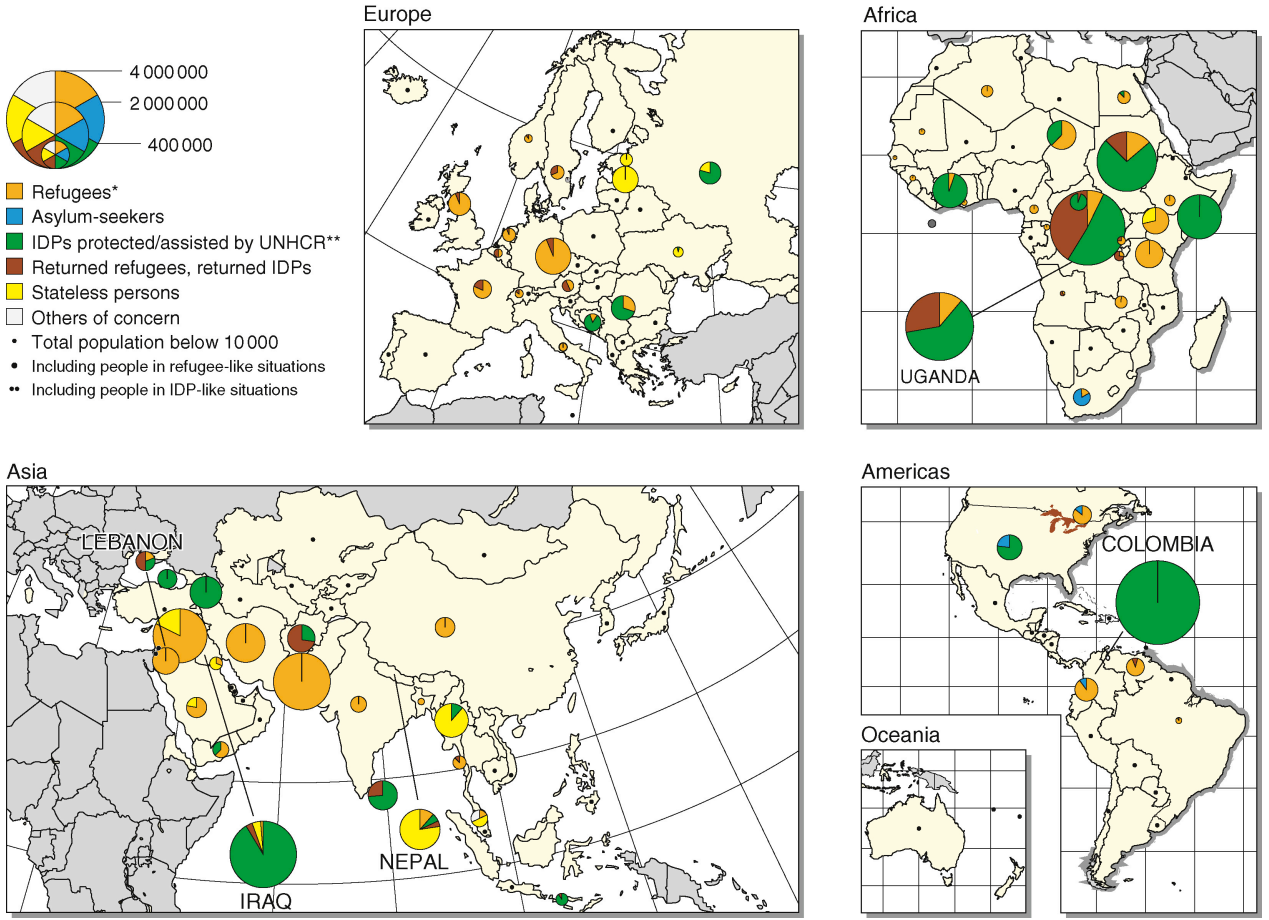

FIGURE 11.1 *Refugees, Internally Displaced Persons, and Stateless Persons Worldwide in 2007. (Reprinted by Permission of the United Nations, Map 1 from 'Global Trends: 2007' http://www.unhcr.org/statistics/STATISTICS/4852366f2.pdf).*

live in confined camps or crowded public shelters or housing in which they are vulnerable to assault (including rape), robbery and illness. Many have witnessed horrific violence during the war, genocide or other forms of mass armed conflict that caused them to flee. Losses of family and friends due to violence or illness are common, as well as due to being separated with no way to communicate. As a result, studies have documented high prevalence levels of PTSD and depression among refugees or IDPs from armed conflicts in Central America, Southeast Asia, the Middle East and the Balkans (Fazel et al., 2005; Marshall et al., 2005) at least ten times higher than the 1–3% prevalence estimates from epidemiological surveys (see Chapter 3). PTSD prevalence estimates that are more than three times as high as even these very high levels, as high as 30–34%, have been reported among disabled Central American refugees (Rivera et al., 2008) and among Afghan mothers (Seino et al., 2008).

Other studies have more specifically investigated the role played by displacement in the traumatic stress experienced by refugees. A review of 56 reports involving 67 294 participants (22 221 refugees and 45 073 persons who were not displaced) showed that displacement alone was associated with more severe mental health problems including PTSD (Porter and Haslam, 2005). Displacement may involve many stressors and the research review found that 'living in institutional accommodation, experiencing restricted economic opportunity, [being] displaced internally within their own country [or] repatriated to a country they had previously fled or whose initiating conflict was unresolved' were particularly problematic. In contrast to most research findings on the etiology (see Chapter 3) and epidemiology (see Chapter 4) of PTSD, 'refugees who were older, more educated and female and who had higher predisplacement socioeconomic status and rural residence also had worse outcomes' (Porter and Haslam, 2005, p. 602).

People become 'internally displaced' as often due to mass natural disasters as to armed violence. In the USA, several hundred thousand people had to leave the New Orleans area following Hurricane Katrina in August 2005. Almost 400 000 received medical care at American Red Cross Shelters within the next month (Mills et al., 2007). Many displaced persons already were severely disadvantaged due to living in poverty (roughly 28% of the population of New Orleans), having limited access to quality health care and exposure to community violence (Mills et al., 2007). In a study of 132 adult evacuees from New Orleans and surrounding parishes (56% men, average age 43 years old, 74% Black, 82% low income (annual income less than $30 000; 67% reporting a pre-hurricane psychiatric disorder (33% depression, 20% anxiety disorder, 8% bipolar disorder)), most (95%) waited several days to be evacuated and a majority reported sustaining minor-to-severe injuries (63%) and mild-to-severe illness (71%) in the hurricane or evacuation process. One in seven lost a loved one due to death in the hurricane or its aftermath and most (85%) were separated from a family member for a day or more. Many (70%) lost their home, two-thirds of whom had no property insurance. Almost two in three (62%) reported symptoms sufficient to qualify for a diagnosis of acute stress disorder (ASD), particularly women, people with a prior psychiatric disorder and those who recalled feeling their lives were in danger during the hurricane or its aftermath, were injured physically or felt they had limited control over their current life circumstances.

Natural disasters of several magnitudes greater have occurred in less developed and affluent areas of the world. For example, the tsunami that struck December 26, 2004 in the wake of the Sumatra–Andaman earthquake killed an estimated 250 000 people along the coastlines of the Indian Ocean, including 130 000 Indonesians. Another half a million Indonesians were displaced from their communities. Studies of survivors of this tsunami from Indonesian areas such as Aceh and North Sumatra (Frankenberg et al. 2008), as well as from Thailand (van Griensven et al., 2008) and Sri Lanka (Hollifield et al., 2008) have demonstrated that posttraumatic stress, anxiety and depression are suffered by hundreds of thousands and perhaps millions of people who experienced psychological trauma due to the tsunami (see Box 11.5).

BOX 11.5 Refugee Posttraumatic Stress in the Wake of Mass Natural Disaster

Frankenberg and colleagues (2008) reported a unique study of the impact of a massive natural disaster, the Indian Ocean tsunami that struck the day after Christmas 2004. Unlike most research on mental health after disaster, this study began with a survey of a representative sample of persons in the host country (Indonesia) almost two years before the disaster. This 'National Socioeconomic Survey (SUSENAS)' provided a registry of respondents and pre-disaster data on health and socioeconomic characteristics of people throughout Indonesia. The 'Study of the Tsunami Aftermath and Recovery (STAR)' attempted to re-contact 39 500 persons interviewed in 585 communities by the SUSENAS.

The study also was able to determine the extent of damage caused to each community by the tsunami. The researchers got data from the National Aeronautics and Space Administration's (NASA's) Moderate Resolution Imaging Spectroradiometer (MODIS) sensor collected one year prior to the tsunami and again immediately after the tsunami, to assess the degree to which the pre-tsunami ground cover visible in the first image had been replaced by bare earth in the second image. Communities with at least 20% loss of ground cover were classified as heavily damaged (15% of the 585 surveyed communities). Those with some loss of ground cover were categorized as moderately damaged (50% of all locales) and 35% with no loss of ground cover were classified as undamaged by the tsunami. Community leaders' and field observers' estimates of damage strongly correlated ($r = 0.84$ and 0.79) with these satellite-based estimates.

One in three of the survey respondents (average age 36 years old) heard the tsunami wave or people screaming. Fewer sustained injuries (3%), lost a spouse (3%), lost a parent or child (5%) or witnessed family or friends 'struggle or disappear' (6%), but 25% lost a family member or friend, 25% lost their home and 15% lost their farming land, livestock or equipment.

Posttraumatic stress was assessed by asking every respondent 15 years or older to answer seven of the items from the PTSD Checklist (see Chapter 6), as follows.

Since the tsunami, have you ever experienced (never, rarely, sometimes, or often) and do you now experience (no, sometimes, often):

(A) Repeated, disturbing memories, thoughts, dreams, or experiences of tsunami

(B) *Feeling very upset when something reminded you of tsunami*
(C) *Avoiding activities or situations because they reminded you of a stressful experience*
(D) *Feeling as if your future will somehow be cut short*
(E) *Trouble falling or staying asleep*
(F) *Feeling irritable or having angry outbursts*
(G) *Being 'super alert', watchful, or on guard*

Exposure to probable traumatic stress due to hearing the wave or screams, being injured or seeing friends or family members 'struggle or disappear', doubled the severity of PCL-C scores. Consistent with this finding, compared to the sleep difficulties reported before the tsunami, after the tsunami there was a large increase in the likelihood of sleep difficulties only in the most heavily damaged areas. PCL-C scores increased the most in the worst damaged locales, followed by the moderately damaged ones, with little change in the non-damaged communities. PCL-C scores averaged 5.77, 4.71 and 2.98 for the heavily, moderately and undamaged areas, respectively, at the time of the interview and had been 33% higher at their peak after the tsunami (based on respondent's recollections). This is consistent with other studies which have reported persistent PTSD symptoms among the worst exposed persons but a substantial decline in PTSD symptom severity over time even among heavily exposed persons (see Chapter 2).

Women reported higher PCL-C scores than men, but primarily only in the heavily damaged areas. Age was a factor in all communities: persons younger than 30 years reporting an increase after the tsunami and persons 50 years and older reporting lower PCL-C scores after the tsunami. Interestingly, respondents who had a parent alive before the tsunami had lower PCL-C scores after the tsunami, but marital status, education and income were not related to post-tsunami PCL-C scores. Property damage also correlated with post-tsunami PCL-C scores.

As Frankenberg and colleagues (2008) note, these findings probably understate the severity and widespread nature of the harm, including posttraumatic stress, caused by a massive disaster such as this tsunami. However, the study provides the strongest evidence to date that communities most directly damaged by a disaster that is not only life threatening for many but that displaces tens or hundreds of thousands of persons from their homes, families, neighbors and way of life has the strongest adverse impact on those who are most directly affected.

Another study (van Griensven et al., 2008) conducted eight weeks after the tsunami in six southwestern provinces of Thailand (where more than 8000 persons died or were unaccounted for and another 8500 were injured), included random samples of 371 displaced persons and 321 non-displaced persons from the most heavily hit area and 368 persons from less damaged areas. Even though the extent of death and destruction was less in the worst hit areas of Thailand than in Indonesia, symptoms of PTSD were reported by 12% of displaced and 7% of non-displaced persons in the most damaged area of Thailand (and by 3% in the less damaged areas). Anxiety or depression symptoms were reported by three times as many persons, with similar proportions depending on displacement and the severity of damage to the community. Thus, this study adds to the findings of the study from Indonesia by demonstrating that displacement from home and community was a factor in PTSD and related symptoms soon after a mass natural disaster.

The Thailand study also re-surveyed participants from the worst-damaged area seven months later (nine months after the tsunami) and confirmed that displaced persons continued to be more likely than non-displaced persons to suffer from PTSD, anxiety and depression symptoms. Consistent with other studies (Ford et al., 2007a) of post-disaster recovery (including the Indonesia study), as the first anniversary of the disaster approached about 40% of each group had recovered sufficiently no longer to report severe symptoms.

Whereas the Indonesia study examined the extent of damage to participants' homes and (for most) the source of their incomes (farmland, animals and equipment), the Thailand study inquired directly as to whether respondents had lost their source of income and found that loss of livelihood was the strongest correlate of PTSD, anxiety and depression symptoms. Thus, the Thailand study showed that losing not only home or community but also one's ability to generate an independent income through gainful work may contribute to the development and persistence of PTSD and related anxiety and depression symptoms. The defining characteristics of becoming a refugee in the wake of disaster therefore include: (1) exposure to life-threatening catastrophe; (2) loss of or separation from family and friends; (3) loss of home and community; and (4) loss of one's personal or family livelihood. Each of these factors may result in acute posttraumatic distress and the combination of several places where people are at risk of persistent PTSD.

As Weine (2008) describes, resettlement of refugees is a substantial challenge not only for displaced persons themselves but also for the host country. Relatively stable and affluent countries in Asia (such as Pakistan, due to Afghan refugees), the Middle East (such as Lebanon and Syria, due to Palestinian refugees) and Africa (such as Kenya and South Africa), as well as most European and British Commonwealth nations and the USA, have had a large influx of refugees. The half of all refugees who are resettled in cities often experience economic pressures due to poverty and low-wage work and must live in communities that are crowded, segregated economically and culturally and often adversely affected by crime, gangs, drugs, AIDS and troubled schools (Weine, 2008). Another half of all refugees are resettled in suburban and rural areas which are more isolated and potentially isolating (www.unhcr.org). In either case, refugees often face prolonged separations from family, friends and loved ones, as well as the burden of having to find a way to subsist while saving money to bring others to their new home and to provide support to those back home who have stayed behind.

Refugee children involve additional needs and challenges, including having to survive life-threatening experiences without adult help or guidance and then having to return to being a 'child' with a new family, community and culture if they are fortunate enough to be permanently resettled (Henderson, 2008). Refugee children therefore often display not only the symptoms of PTSD, but also behavior problems (such as aggression or defiance of authority), profound bereavement and developmental, learning or educational delays or deficits that are understandable in light of their often chronic deprivations before and during displacement. However, children also can be particularly resilient in the face

of the psychological losses and traumas of being a refugee and often are a key source of hope for their families in the resettlement process (Weine, 2008).

Refugees may have several opportunities to receive mental health services, either in the context of a refugee camp or after resettlement, but many refugees do not seek or utilize these services. Survival, getting stable predictable access to food, money, housing, transportation and safety, renewing communication with friends and family and sustaining or regaining connection to cultural and religious traditions, values and practices may take precedence over mental health treatment (and may in fact be the best form of therapy for many, under the circumstances).

In resettlement settings, clinical treatment for refugee trauma is typically organized through refugee mental health clinics or specialized torture victim treatment centers, with services including crisis intervention, psychopharmacology, individual psychotherapy, group psychotherapy and self-help groups (Weine, 2008). To deliver culturally appropriate services, many programs involve traditional healers, socialization or mutual support groups, multi-family groups and culturally-based activities (Weine, 2008). Services also tend to be provided by staff who are themselves members of the refugees' ethnic community, in collaboration with traumatic stress specialists and mental health professionals. The Western culture's traditional model of a professional 'expert' doctor or consultant who unilaterally tells local staff or clients how best to do assessment, diagnosis or treatment has been justly criticized as culturally insensitive (Weine, 2008). Instead, the joint experience and expertise of the refugee client, local professional and paraprofessional helpers, traditional healers and traumatic stress professionals are taken together in a team approach that validates the client's and local helpers' cultures and traditions. This approach enhances the providers' ability to make a true cross-cultural assessment of symptoms and diagnoses, to adapt interventions to reflect different cultural beliefs and practices and to engage not just individual clients but families and communities in recovery from PTSD. Such an approach is consistent with new theoretical views of refugee traumatic stress, which include 'the concepts of cultural bereavement, cultural trauma, family consequences of refugee trauma, community trauma and social suffering' (Weine, 2008). This more culturally-grounded view of refugees' experiences of traumatic stress and recovery from PTSD has led to the development of innovative therapy approaches (such as incorporating personal testimony and reconciliation into treatment) that address refugees' psychological vulnerabilities but strongly acknowledge their (and their families' and communities') hopes and strengths (Weine, 2008).

PROGRAMS ADDRESSING THE SOCIAL AND POLITICAL ASPECTS OF CATASTROPHIC TRAUMATIC STRESSORS

When mass catastrophes, whether human-made or 'natural' in origin, cause tens or hundreds of thousands or even millions of people and families to experience psychological trauma, the resultant suffering and needs are beyond the capacity of traditional mental health services and other forms of government-sponsored

services to address. This includes natural disasters (such as tsunamis, tornadoes, hurricanes, floods or earthquakes), public health emergencies (such as AIDS, severe acute respiratory syndrome (SARS), pandemic influenza) and human-made disasters (such as terrorist attacks, airline crashes and train derailments). Non-governmental organizations (NGOs) play a critical role supporting and assisting persons and communities affected by catastrophic disaster or violence, including providing psychological support through clinical and non-clinical behavioral health services (Hamilton and Dodgen, 2008).

NGO responses to the mental health needs of mass disaster survivors are based on the core belief that 'all disasters are local' (Hamilton and Dodgen, 2008). This means that local responders such as law enforcement, police, emergency medical teams and professionals from the healthcare facilities, schools and government are invariably first on the scene and frequently remain involved for months or years afterward. When insufficient resources are available, a local community may request help from the country, state or provincial governments, which in turn may request regional or national assistance from both government and private sectors. For that reason, NGOs that provide assistance following disasters, such as the American Red Cross, the National Voluntary Organizations Active in Disaster (NVOAD), United Way and Salvation Army do so through their local chapters which organize the initial relief efforts to provide shelter, food, legal aid, health and mental healthcare and humanitarian assistance. Organized in 1970, NVOAD is the umbrella organization coordinating all disaster relief services provided by volunteer organizations such as American Red Cross throughout the USA.

NGOs also work closely with faith-based organizations (FBOs) in the USA (such as Catholic Charities United States, Church World Service, Lutheran Disaster Response, National Association of Jewish Chaplains) within the National Response Framework of the Federal Emergency Management Agency (FEMA), which guides the nation's 'all-hazards incident response' (Hamilton and Dodgen, 2008). For example, American Red Cross disaster mental health (DMH) volunteers provide mental health services to people in shelters while the Church of the Brethren provides crisis intervention to young children through their Disaster Child Care (DCC) program (Hamilton and Dodgen, 2008).

The American Red Cross is the most widely recognized NGO providing disaster mental health services in the USA. In 1905, Congress chartered the American Red Cross to 'carry on a system of national and international relief in time of peace', to reduce and prevent the suffering caused by national calamities program (Hamilton and Dodgen, 2008). In 1990, the American Red Cross established a formal DMH Services program and began training licensed and certified mental health professionals to volunteer and assist other Red Cross workers cope with and recover from the traumatic stress (or 'vicarious trauma') of their disaster relief work. Initially, only licensed psychologists and social workers were permitted to become Red Cross DMH volunteers but, recently, professionals from other disciplines such as psychiatry and master's level marriage and family therapy or counseling professions also have become eligible.

The American Red Cross has set up formal agreements with the American Psychiatric Association, the American Psychological Association, the National

Association of Social Workers, the American Counseling Association and the American Association of Marriage and Family Therapy. The agreements provide that, in the event of a mass disaster, the Red Cross will notify each professional association to put out a call to their memberships for professionals who have completed Red Cross preparatory training and who can take time out from their ordinary work to serve as DMH volunteers for two weeks or more at Red Cross disaster services sites.

The American Red Cross sets up and oversees Family Assistance Centers (FAC) for disaster-affected communities, provides crisis and grief counseling through its DMH volunteers and coordinates with federal agencies such as FEMA and the National Transportation Safety Board (NTSB; for airline or mass transportation disasters) to provide childcare services and inter-faith memorial services. The Red Cross also works closely with disaster-focused NGOs such as the National Organization for Victim Assistance (NOVA), Disaster Psychiatry Outreach and the International Critical Incident Stress Foundation, Inc. (ICISF). Founded in 1989, the ICISF trains mental health professionals, emergency responders, clergy, and chaplains to conduct critical incident stress management (see Chapter 9) teams to support disaster services personnel.

In 2005, the American Red Cross broadened the scope of DMH services to include assisting disaster-affected persons who are seeking Red Cross assistance as well as Red Cross volunteers. All DMH volunteers now are trained in Psychological First Aid (see Chapter 9), so that they will provide mental health services to disaster victims in an appropriately circumscribed manner that is therapeutic without attempting to conduct psychotherapy at a disaster relief site.

Two other freestanding programs participating in a DMH response are the Green Cross Assistance Program, which provides trained traumatology specialists and the Association of Traumatic Stress Specialists (ATSS), an association of mental health professionals and paraprofessionals who assist survivors of psychological trauma (Hamilton and Dodgen, 2008).

A number of US NGOs also work internationally to provide psychosocial support and traumatic stress counseling to survivors of disasters and mass conflicts. These include the International Services of the American Red Cross, the United Methodist Committee on Relief (UMCOR), Church World Services, Green Cross, Action Aid–United States, the American Refugee Committee, The Center for Victims of Torture and Doctors Without Borders (Hamilton and Dodgen, 2008). The International Federation of Red Cross and Red Crescent Societies also assist many nations' Red Cross organizations in serving their own and neighboring countries.

A 2006 analysis by the United States Homeland Security Institute found that FBOs and NGOs had a significant beneficial impact during and after Hurricanes Katrina and Rita with mental health and spiritual support among ten types of services (Hamilton and Dodgen, 2008). The study reported that while FBOs and NGOs faced significant limitations and challenges in providing services, mental health and spiritual support was one of the three best-applied special practices, particularly services designed to preserve family unity within disaster relief shelters.

Hamilton and Dodgen (2008, p. 451) describe how NGOs can work together to meet critical needs in times of mass crisis, using the September 11, 2001, terrorist attacks in New York, Washington and Pennsylvania, as a case in point:

> Local mental health providers working in mental health settings mobilized quickly, but needs were expected to surpass local capability. The American Red Cross dispatched DMH providers from local and adjacent communities to provide mental health support and stress reduction assistance. National volunteers recruited from across the country arrived within a few days to augment that mission. Concurrently, ICISF-trained volunteers, some of whom were already part of military mental health systems, also arrived to provide assistance. Other agencies, such as FBOs, also organized support for victims. In Washington, the military was the gatekeeper for volunteers and worked closely with the American Red Cross to coordinate mental health support. In New York, civilian authorities collaborated with the American Red Cross. As family assistance centers were set up to aid grieving families, national DMH volunteers continued providing mental health support. Because the terrorist attacks created a crime scene, access was controlled and NGOs needed official standing to provide assistance. Incorporating lessons learned from 9/11, a similar event today would be different in several ways: all NGOs and government agencies would organize their response under the National Incident Management System (NIMS) and the NRF, thus creating a more centralized, coordinated response and reducing overlapping or competing activities on the part of NVOADs. Because of ongoing coordination and outreach efforts since 9/11, a greater array of disciplines and specific types of expertise would be available through NGOs. The benefits of these efforts were seen during the responses to Hurricanes Katrina and Rita in 2005.